Tandarts N. Kaufman
Oranje Nassaustraat 58
1165 GN Halfweg
020-6592252
nivdent@hotmail.com
Big. 39062083002
NMT

Medical and personal information

Certain diseases and defects can greatly influence your oral health, as can your lifestyle and any medications taken. The can also lay restrictions on your treatment or from the basis for decisions concerning certain preventive mesures during the treatment. Therefore, it is very important that your dendist and oral hygienist be informed of the pertinent details of your medical history. Your history will be treated confidentially under the code of medical ethics.

Please cirkcle the right answer

1.	Do you experience pain or pressure in your chest upon exertion (angina pectoris)?	Yes / No
	If so,	
	*have you had to reduce your activities?	Yes / No
	*do you experience these symtoms when at rest?	Yes / No
	*have you experienced thes symtoms with increasing frequency in the past few months?	Yes / No
	*despite a bypass, dottering or lasertherapy, has angina pectoris returned?	Yes / No
2.	Have you ever had a heart attack?	Yes / No
	If so,	
	*was it followed by complications?	Yes / No
	*do you still have any symptoms?	Yes / No
	*have you had a heart attack within the last 6 months?	Yes / No
3.	Do you have a heart murmur, a dysfunction of the heart valve, or have you had acute theuma? If so,	Yes / No
	*do you have any symptoms now?	Yes / No
	*has you heart valve been operated on?	Yes / No
	Do you have an artificial heart valve, a vascular prothese or artificial joints?	Yes / No
	If so,	
	*have you continued to exoerience symptoms after your operation?	Yes / No
	*because of this problem, do you require antibiotic profylaxis before a dental treatment?	Yes / No
	Have you had heart surgery within the last 6 months?	Yes / No
	If so,	
	*was this a 'bypass' operation?	Yes / No
	*do you still have any symptoms?	Yes / No
	*do you still have angina pectoris?	Yes / No
	Do you have a pacemaker?	Yes / No

4.	Do you have heart palpatations without exerting yourself?	Yes / No
	If so,	
	*during these attacks do you need to reduce your activities, sit down or lie down?	Yes / No
	*do you become pale, dizzy or short of breath during these attacks?	Yes / No
	*are you taking anticoagulants?	Yes / No
5.	Do you suffer from heart failure?	Yes / No
	If so,	
	*do you ankles swell at night?	Yes / No
	*do you have to urinate more than twice during the night?	Yes / No
	*do you sleep with more than two pillows because of shortness of breath?	Yes / No
	*after climbing twenty steps, do you need to rest because of shortness of breath?	Yes / No
	*do you ever wake up during the night due to shorness of breath?	Yes / No
6.	Do you suffer from hyperventilation?	Yes / No
7.	Have you ever fained during a dental or medical treatment?	Yes / No
8.	Do you have high bloodpressure?	Yes / No
	If so,	
	*is the systolic (upper) pressure usually between 160 and 200?	Yes / No
	*is the systolic (upper) pressure usually 200 or higher?	Yes / No
	*is the diastolic (lower) pressure usually between 95 and 115?	Yes / No
	*is the diastolic (lower) pressure usually 115 or higher?	Yes / No
9.	Have you ever had a stroke or attack resulting in paralysis or speach defects?	Yes / No
	If so,	
	*are you taking anti-coagulants or asprin products?	Yes / No
	*did the symptoms disappear within 24 hours?	Yes / No
	*have you had a stroke in the last 6 months?	Yes / No
10.	Are you taking medicine for epilepsy?	Yes / No
	If so,	
	*does your doctor have to adjust your medication frequently?	Yes / No
	*do you continue to have attacks?	Yes / No
11.	Do you have asthma?	Yes / No
	If so,	
	*do you have complaints at this moment?	Yes / No
	*do your medicines fail to help at this moment?	Yes / No
12.	Do you have problems with your lungs?	Yes / No
	If so,	
	*do you have tuberculosis?	Yes / No
	*do you suffer from any symptoms of tuberculosis at this moment?	Yes / No
	*do you cough up more than one cup of mucuc a day?	Yes / No

*are you short of breath after walking up 20 steps? Yes / No
*are you short of breath when you wake up or when you are getting dressed? Yes / No

13. Do you have hay fever or have you ever had an allergic reaction to medication or medical Materials (iodine, rubber)? Yes / No
If so,
*are you taking medicine for your allergy? Yes / No
*have you ever had an allergic reaction to local anesthesia? Yes / No
*have you ever had an allergic reaction in a dental office? Yes / No
*are you short of breath when you wake up or when you are getting dressed? Yes / No

14. Do you have diabetes? Yes / No
If so,
*are you taking insulin? Yes / No
*is your blood sugar level freguently disordered? Yes / No
*are you being treated for heart or vascular disorders connected with diabetes? Yes / No

15. Do you have an excessive activity of the thyroid gland (hyperthyroidism)? Yes / No
If so,
*are you receiving treatment or going in for checkups? Yes / No
*do you have any symptoms now? Yes / No
Have you lost more than 12 pounds of weight in the past 6 months, without a special diet? Yes / No
If so,
*are you less tolerant of heat than other people? Yes / No
*do you have clammy hands or trembling fingers? Yes / No

16. Do you have a deficient activity of the thyroid gland (hypothyroidism)? Yes / No
If so,
*are you receiving treatment or going in for checkups? Yes / No
*do you have any symptoms now? Yes / No
Have you gained more than 12 pounds of weight in the past 6 months, without eating More than usual? Yes / No
If so,
*are you physical reactions excessively slow? Yes / No
*are you more sensitive to cold than other people? Yes / No

17. Have you had a chronic liver disease (longer than 6 months)? Yes / No
If so,
*have you ever been hospitalized for this liver disease? Yes / No
*are you on a special diet or are you taking medication for this liver disease? Yes / No
Do you have serum-hepatitis or hepatitis B? Yes / No
If so,
*was this established by laboratory examination? Yes / No
*are you still receiving treatment or having checkups? Yes / No

18. Do you have a chronic kidney disease? Yes / No
If so,
*are you receiving rental replacement therapy? Yes / No

*are you on a special diet, or are you taking medication for this kidney disease? Yes / No

19. Do you have protracted gastrointestinal complaints accompanied by diarrhea? Yes / No
If so,
*do you have diarrhea during the night? Yes / No
*have you had diarrhea lasting longer than 6 months? Yes / No
*is the diarrhea accompanied by fever? Yes / No

20. Do you have anemia? Yes / No
If so,
*do you have symptoms, such as tiredness, dizziness, headaches or shortness of breath? Yes / No
*does hereditary anemia run in your family? Yes / No

21. Do you have a malignant disease of the lymph nodes or a blood disease? Yes / No
If so,
*which?
*do you have oral ulcers or inflammations? Yes / No
*do you still have symptoms despite treatment? Yes / No
*do you have attacks of fever? Yes / No
*do you perspire profusely at night? Yes / No

22. Do you suffer from abnormal bleeding? Yes / No
If so,
*do you bleed more than an hour after injury or surgery? Yes / No
*do you bruise easily? Yes / No
*are you taking ant-coagulants? Yes / No
*are you taking aspirin more than twice a week, or are you taking another medication for arthritis or pain in the joints? Yes / No
*do bleeding disorders run in your family? Yes / No

23. Have you had x-ray treatment for a tumor growth or other condition of the head or neck? Yes / No
If so,
*was this more than five years ago? Yes / No
*was this between one and five years ago? Yes / No
*was this in the last year? Yes / No

24. Do you have a contagious disease? Yes / No
If so,
*which? Yes / No
*are you sero-positive? Yes / No
*do you have aids?

25. Are you taking medicines now? Yes / No
If so,
*drugs for heart trouble? Yes / No
*anticoagulants? Yes / No
*medication for high blood pressure? Yes / No
*aspirin or other medication for arthritis or pain in the joints? Yes / No

	*medication for diabetes?	Yes / No
	*cortisone, prednisone or other immunosuppressant?	Yes / No
	*cytostatics?	Yes / No
	*antibiotics?	Yes / No
	*tranquillizers or sleeping pills?	Yes / No
	*other drugs?	Yes / No
26.	Are you pregnant?	Yes / No
27.	Do you smoke?	Yes / No
	Do you drink more than two glasses of alcohol a day?	Yes / No
	Do you suffer from stress?	Yes / No
28.	Do you have a bad taste in your mouth?	Yes / No
	Do you have bad breath?	Yes / No
	*do you notice it yourself	Yes / No
	*do others notice that you have bad breath?	Yes / No

Attention

You should inform us should any changes occure in the information you have provided us with.

Name + initials:_____M / F

Sreet_____

Postal code_____City_____

Date of birth_____

Tel #private_____Tel#work_____

Occupation_____

How are you insured? – Privately with_____

National health service with_____Policy number_____

General Practitoner_____Specialist_____

I declare that the above information is correct to the best of my knowledge and belief,

Date_____At_____

Signature_____